

[illegible]

Mental Status/Psychosocial Status

Safety Measures/Functional Limitations (Specify)

Assistive Devices Used

Crisis Intervention Plan Medical

Crisis Intervention Plan Psychological

| FUNCTIONAL OVERVIEW KEY: I = Independent N = Needs Assistance D = Dependent | | | | | | | | | | | |
|--|---|---|---|----------|-----------------|---|---|---|----------|--|--|
| TASK | I | N | D | Comments | TASK | I | N | D | Comments | | |
| Bathing | | | | | Laundry | | | | | | |
| Dressing | | | | | Housekeeping | | | | | | |
| Exercise | | | | | Vision | | | | | | |
| Grooming | | | | | Communication | | | | | | |
| Toileting | | | | | Medication Mgmt | | | | | | |
| Continence | | | | | Medical Mgmt | | | | | | |
| Transfer | | | | | Money Mgmt | | | | | | |
| Mobility | | | | | Behavior Mgmt | | | | | | |
| Meal Preparation | | | | | Memory | | | | | | |
| Diet | | | | | Time Mgmt | | | | | | |
| Eating | | | | | Socialization | | | | | | |
| Shopping | | | | | Other | | | | | | |
| Escort | | | | | Other | | | | | | |
| Transportation | | | | | Other | | | | | | |

| OTHER TREATMENT/THERAPIES/SOCIAL SERVICES AND INFORMAL SUPPORT SYSTEMS | | | |
|--|--------------|----------|-----------|
| SERVICE | PROBLEM/NEED | PROVIDER | FREQUENCY |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PLAN ASSESSMENT SUMMARY**PHYSICAL SUMMARY:**

Long term goals:

Short-Term Objectives:

PSYCHOSOCIAL SUMMARY:

Long-Term Goals:

Short-Term Objectives:

Past Successes:

DISCHARGE PLANI have a free choice of all qualified providers of HCBS for each service included in my Plan of Care. ☐I understand there is a Plan of Care cost limit and a limit on the type of services available through the HCBS program. ☐I have participated in the development of this Plan of Care and agree with it. ☐

Recipient: _____ (Signature) _____ (Date)
 Legal Representative: _____ (Signature) _____ (Date)

Significant Other: _____ (Signature) _____ (Date)
 CMT Nurse: _____ (Signature) _____ (Date)

Health Care Professional: _____ (Signature) _____ (Date)
 CMT Social Worker: _____ (Signature) _____ (Date)

Community Program Officer: _____ (Signature) _____ (Date)